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Community-Based Long Term Care:

Descriptive Summaries of Statewide Programs in Illinois and Colorado

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Community-Based Long-Term Care: Descriptive Summaries of Statewide Programs in Illinois and Colorado

I. INTRODUCTION

In the Spring of 1984, the Administration on Aging executed a small contract for a follow-up project to examine the current status of State Unit on Aging activities related to long-term care (LTC) in five of the fifteen states that had received LTC system development grants. These competitively awarded one year planning grants, funded by the Administration on Aging (AoA) in the Fall of 1980, were aimed at addressing the fragmentation and increasingly unacceptable cost and program inefficiencies that characterized existing LTC planning and service delivery. The intent of the system development grant awards was to stimulate a more coordinated approach to LTC policy and program development within and between the principal state level agencies responsible for organizing, financing and managing LTC services and programs for older people.*

This report is one product of the follow-up project. It presents descriptive summaries of LTC programs currently being implemented under the auspice of the State Units on Aging (SUAs) in Illinois and Colorado, two of the five states that were included in the project. The programs that are described reflect significant expansions of the role of these SUAs with respect to LTC program development and service delivery. In both Illinois and Colorado, the SUAs have been acknowledged as the principal agency responsible for implementing and managing statewide community-based LTC service systems. In both states, the

*The System Development Grant Program was one component of a larger collaborative effort among several agencies within the Department of Health and Human Services which, in 1980, mounted a major long-term care initiative that included the National Long-Term Care Channeling Demonstration Program.

SUAs also have been given the authority to administer considerable resources beyond those available to them through the Older Americans Act, including resources that traditionally might have been incorporated within the administrative aegis of the states' Medicaid agencies.

Given these similarities, Illinois and Colorado are also illustrative of two very different origins and approaches to community-based LTC program development and service delivery. The original Community Care Program (CCP) administered by the Illinois SUA pre-dated by several years the state's receipt of 2176 Medicaid waivers. When the Illinois waiver program was implemented, it was incorporated into a pre-existing substate structure that had been put in place and was already being managed by the SUA to address the LTC needs of older people. Although programmatically and structurally, the Community Care Program is now considerably different than it was when it was implemented initially, the Medicaid waivers had a minimal effect on the changes that occurred. Currently, the CCP operates through a network of locally-based Case Coordination Units that serve all older people who meet the program's eligibility requirements. Income is not a criterion for determining eligibility for program participation.

On the other hand, the Colorado Home and Community-Based Services (HCBS) Program administered by the SUA was legislatively conditioned on the state's receiving approval of its 2176 waiver proposals and is clearly framed by both the waiver specifications and extant Medicaid Program requirements. In contrast to the Illinois CCP, the Colorado HCBS Program serves non-aged adults as well as older people, program participation is income-restricted, and the program structure is largely mirrored by the state's pre-existing Medicaid Program.

Another relevant feature that distinguished the Illinois and Colorado programs is the extent to which the SUAs have established program linkages with their substate area agency networks and with other service components under their immediate control. In Illinois, where the SUA program components are limited to those mandated under the Older Americans Act and to its Community Care Program, its area agency on aging network is both structurally and programmatically linked to the CCP. In Colorado, these connections are much more tenuous, in terms of the role of Colorado's area agencies in relation to both the HCBS Program as well as the other program components currently being administered by the SUA.

The program descriptions that follow are not intended to be all-inclusive. Rather, they present snapshot summaries of what each program looks like, how it was developed and how it works. Their purpose is twofold. With respect to AoA, the program summaries are aimed at providing information it might find useful in relation to its LTC advocacy role at the federal level. The involvement of the Illinois and Colorado SUAs in community-based LTC program development and service delivery is illustrative of the significant role that an increasing number of AoA Network agencies are playing in relation to meeting the LTC needs of the nation's older population. As the federal locus for Network activities, AoA can capitalize on the widespread and expanding role of its Network agencies in community-based LTC policy and program development at the state and local levels.

The program descriptions also are intended to stimulate interest among those SUAs that are less far along, to consider how they might assume a more active role in relation to system-oriented LTC program development and service

delivery. The Illinois and Colorado experiences can be seen as examples of what might be undertaken in other states.

As background and context for the program descriptions that follow, the next section presents an overview of the development of community-based long-term care and the emergence of the concept of long-term care system development.

II. BACKGROUND

A. Overview of the Development of Community-Based Long-Term Care

Since its inception in 1965, and through most of the 1970's, the Medicaid Program was essentially the only Federally-supported public resource for long-term care, and nursing homes were by far the predominant locus for publicly-supported LTC service delivery. Although state Medicaid programs also included non-institutional LTC-related services, these were modest in scope, highly restrictive in terms of eligibility, and marginal with respect to the total Medicaid budget being expended for LTC. There was no question that during much of this time, the public policy paradigm equated LTC with nursing home care and identified the state Medicaid agency as the focal point for state level LTC planning and program development.

Beginning in the early 1970's, however, attention started to be focused on the discontinuities and inequities inherent in the then current system for organizing and delivering LTC services to the nation's older population. In concert with the concerns that were being voiced in the public arena about the spiraling costs of nursing home care and the substandard care that far too many nursing homes were found to be providing, still another dimension was introduced into the public policy debate.

Expressing their dissatisfaction with the limitations associated with viewing nursing homes as the pre-eminent public response to meeting the LTC needs of older

people, a small group of concerned professionals, including representatives of several State Units on Aging, took the position that the definition and scope of LTC should be broadened. Under the banner of "alternatives to institutionalization," they began concentrating their efforts on developing a range of community-based LTC options for those older people who did not require the scope and intensity of care available in a nursing home setting, and who would prefer to remain at home — if the support services they needed were there for them to do so.

These early seeds, nurtured by continuing concerns about the costs and quality of institutional care and by a combination of empirical evidence and intuitive judgment that a not insignificant proportion of nursing home residents could and would prefer to be cared for in a non-institutional setting, bore fruit. The ensuing years evidenced considerable growth in public interest and support for developing a broader base of LTC services, primarily by expanding the community care component of LTC.

B. Emergence of the Concept of Long-Term Care System Development

By the end of the decade, increasing acceptance of the concept of community care and the growth of public support for community care service options had become evident in a number of states across the country. Despite its positive aspects, however, the acceptance of community-based LTC as a legitimate service modality introduced a series of new complexities affecting state level LTC policy and program development. Among these were major concerns related to LTC program fragmentation, which was not at issue when nursing homes and LTC were essentially synonymous and the state Medicaid agency was the single state level administrative entity responsible for LTC planning and service delivery.

State Medicaid agencies continued to be responsible for funding and managing the institutional-based nursing home component of LTC, as well as the far more limited but by no means insignificant non-institutional LTC services available under the State Medicaid Plan. By 1980, however, the scope and structure of LTC in a number of states had become very different.

- Older Americans Act resources administered by SUAs were increasingly being expended on LTC-related efforts, particularly on designing and implementing community care services and programs at the substate level.
- Title XX funds (soon after to be administered under the Social Services Block Grant Program) were being designated to support community care services for older people. In several states, these resources were being subcontracted to SUAs. However, in others, the responsibility for their administration was being retained within the non-categorical state social service agency.
- Significant amounts of state funds were being appropriated to support community care services and programs for older people, frequently, although not exclusively, under the auspice and management of SUAs.

Although there may have been a few exceptions, these incremental service expansions created an environment for program dissonance, as each of the state agencies that had become involved in LTC-related activities defined, operationalized and managed its objectives in terms of its own federally-mandated and state-determined parameters.

By 1980, it had become increasingly apparent that the emerging multiplicity of structures through which LTC services and programs were being developed and managed were inefficient, from the perspectives of both cost and appropriate responsiveness to client need. At the same time, a consensus was developing regarding the necessity and increasing urgency to begin correcting these inefficiencies, given future projections of the need and demand for LTC that were likely to begin surfacing as the elderly population got both larger and older.

Especially in those states that had already expanded, or were considering expanding LTC to include a community-based LTC service modality, these themes provided the impetus for looking at LTC more systematically, i.e., for examining all of the various services and programs that collectively made up LTC, in terms of how they relate to one another rather than as a series of essentially independent responses to LTC needs. The conceptual goal was clear: to create a LTC system that includes not only an appropriate range of community care services, but also the structural and administrative mechanisms necessary to relate and link these services to one another and to the institutional component of LTC, in a manner that is most cost-efficient and program-effective.

The program summaries that follow are examples of two states' efforts to attain this goal. Neither of them currently has a fully developed system in place, nor the commitments that are likely to be needed to make it happen. Each of them, however, reflects an evolutionary phase in the process.

III. PROGRAM SUMMARIES

What follows are summary descriptions of the statewide community care programs currently being administered by the SUAs in Illinois and Colorado. As stated previously, they represent examples of the pivotal role SUAs are now playing with respect to meeting the LTC needs of older people. Before proceeding, it is important to note that both programs are in transition, accommodating to a variety of political, fiscal and programmatic factors that continue to emerge within each state. In Illinois, where the Community Care Program actually had its origins in a SUA effort begun in the late 1970's, the evolutionary process has a considerable history. The Colorado Home and Community-Based Services Program, on the other hand, is a much more recent effort that is still in the beginning throes of its development.

The Illinois Department on Aging Community Care Program

A. Historical Context

The cabinet level Illinois Department on Aging (IDOA) was among those State Units on Aging that had begun focusing their attention on community-based LTC in the 1970's. However, it took several years before the SUA succeeded in its efforts to gain visibility and credibility as a principal agency with a major role to play in relation to providing LTC services for older people. Official acknowledgement came in 1979, when the Illinois General Assembly legislatively transferred a previously mandated state program of community-based LTC services "to prevent premature or unnecessary institutionalization" out of the Department of Public Aid (the agency responsible for administering the state's Medicaid Program). Administrative responsibility for that portion of the program aimed at addressing the community-based LTC needs of the 60 years of age and older population was given to the IDOA; responsibility for administering the services related to adults under 60, was given to the Illinois Department of Rehabilitation Services.

By January 1, 1980, the IDOA had begun implementation of its first iteration of the Illinois Community Care Program (CCP). Using the resources it had available, Older Americans Act Title III funds and a $9 million state Title XX appropriation, the SUA opted to focus on three services that would be supported directed by the CCP: chore/housekeeping, homemaker and adult day care.

To implement the CCP at the substate level, case management units were created within each of the SUA's 13 area agencies on aging (AAAs). These case management units were responsible for client assessment, care planning and services acquisition and monitoring. Each AAA also negotiated a series of contracts with local non-profit agencies, and even made arrangements with individuals, to provide the services that

were determined to be needed, when these were not available to program clients from other publicly-supported, private or informal resources.

Because the General Assembly explicitly stipulated when it transferred the program that income should not be a factor in determining eligibility, need for service became a principal criterion for program participation. A screening instrument, geared to measuring functional need, was adopted and used by case managers to determine whether an applicant met the minimal need level established for participation in the CCP. Another instrument also was used, but for a somewhat different purpose. It was designed to relate functional disability to anticipated costs of care should the individual be institutionalized. The purpose of this latter determination was to set a cost ceiling on the services that could be provided to individual clients through the CCP.

During the first year of CCP implementation, the SUA, in its attempts to both maximize available resources and streamline program operations, made a number of administrative changes in the program. Major among these was its decision to shift client assessment and case management functions from the AAAs to non-network entities in each planning and service area (PSA), and to give AAAs oversight and supervisory responsibilities in relation to managing service provider contracts.

By the end of June, 1981, close to 10,000 clients were being served by the Community Care Program and, because its resources were insufficient to meet the demand the program was generating, another 4,000 applicants were on the CCP waiting list. As a result of these pressures against the system, the program moved into a maintenance mode, and new clients were accepted only as replacements for those who left.

The following two years evidenced a number of additional program changes, precipitated primarily by three events. The first, and perhaps most significant,

was in 1982, when a Court ruling was issued in support of a suit that had been filed challenging the SUA's waiting list for CCP services. The Court Order had the effect of changing the nature of the CCP from a limited grant program to what is essentially a state entitlement program for community care services. The second event, which occurred in the summer of 1983, was the state's success in gaining approval for a set of waivers that had been authorized under Section 2176 of the 1981 Omnibus Budget Reconciliation Act. These waivers permitted Illinois to receive its usual 50 percent federal Medicaid reimbursement for services that might not otherwise be claimed according to extant Medicaid regulations. The third precipitating event also occurred the same summer, when the state initiated a nursing home pre-screening program for all eligible Medicaid applicants for nursing home care, as well as for those applicants who were likely to become Medicaid-eligible within 60 days of admission.

As will be described in the next section, these actions have had a major effect on both the SUA and its Community Care Program; the role of the SUA vis-a-vis state level LTC system development was even further reinforced, and the Community Care Program reflects a number of changes that were undertaken in order to accommodate to the new circumstances under which it was required to operate.

B. Summary Description of the Current Illinois Community Care Program

1. PROGRAM STRUCTURE

The Illinois Community Care Program, which is currently serving 21,000 clients per month, is administered through a four-tiered structure that includes approximately 150 direct service provider agencies, 63 "case coordination units," 13 area agencies on aging and, at the state level, the Illinois Department on Aging. The functions of each of these components are summarized below.

a.) Direct Service Providers. Through a competitive bidding process initiated by the SUA, a number of provider agencies have been identified as CCP vendors. Under contract with the SUA, each vendor operates within one or more of the 63 defined geographic areas of the CCP. In addition to delivering approved services to CCP clients, vendor agencies are also responsible for notifying the CCP of any observed changes in client condition or circumstances.

b.) Case Coordination Units. A total of 63 case coordination units (CCUs) have been established statewide to provide coverage for the Community Care Program. CCUs are housed in several different types of community agencies, e.g., home health agencies, County Health Departments, multi-service senior centers, family service agencies, etc. CCU agencies are under contract with the SUA to provide assessment and case management services to CCU clients. At present, state agency regulations preclude CCUs from being CCP vendors.

Each agency employs case managers, who are responsible for assessing client need, determining client eligibility for participation in the CCP, care planning and services acquisition and monitoring. In addition to their efforts to access non-CCP services that are needed by and available to their clients, case managers are empowered to authorize the provision of CCP services from approved vendors. (CCU functions are not limited to the Community Care Program. Area agencies, using their Title III funds, also support CCUs to provide client assessment and case management services -- exclusive of service purchase authority -- for those older people who need LTC but who do not meet the eligibility requirements for CCP participation.)

CCU case managers are also responsible for administering the state's nursing home pre-screening initiative. As such, they function as LTC gatekeepers; where appropriate, they can offer a package of community care services in lieu of institutional care.

c.) Area Agencies on Aging. Thirteen area agencies on aging, of which 12 are non-profit corporations and one is a unit within city government (Chicago), are responsible for planning and coordinating aging services in their planning and service areas, in accordance with the provisions of the Older Americans Act. Their specific responsibilities in relation to the Community Care Program include monitoring the performance of CCP vendors and CCUs, providing technical assistance and coordinating the activities of and relationships between the CCUs and the CCP vendors operating within their PSAs.

d.) The State Unit on Aging. In addition to its specifically mandated functions under the Older Americans Act, the Illinois Department on Aging has been given state legislated responsibility and authority to design the Community Care Program and to manage its various components. In this capacity, its functions include negotiating contracts with local vendors and CCUs; establishing program and fiscal policies and providing assistance as needed in their implementation; collecting and analyzing relevant program and fiscal data; reimbursing invoices submitted by vendors and CCUs; tracking and identifying Medicaid clients who are participating in the CCP; transmitting relevant information to the state Medicaid agency so that Medicaid reimbursement can be claimed for CCP services provided to Medicaid-eligible clients; and generally performing the range of administrative and management functions needed to ensure the smooth operations of the program.

2. PROGRAM SERVICES

In addition to the assessment, nursing home pre-screening and case management functions performed by the CCUs across the state, the Community Care Program currently makes funds available to support three direct services:

- o chore/housekeeping, which is defined as assistance with household tasks, e.g., vacuuming, light dusting, laundry, trash removal, etc.;

- o homemaker service, which may include the above, but also incorporates a personal care function, e.g., assistance with bathing, grooming, dressing, etc.; and
- o adult day care, which provides social interaction, therapy and rehabilitation activities and general oversight in a structured congregate setting. Day care also can serve as a substitute for family members who work and as respite for primary caregivers.

Although only these three services are currently reimbursed under the CCP, the program, through its case managers, utilizes services funded by other sources to the extent possible, e.g., Title III, Medicaid, Medicare, United Way and other private sources, and also a variety of services provided by organized volunteer groups and individual volunteers.

3. PROGRAM ELIGIBILITY CRITERIA AND ELIGIBILITY DETERMINATION PROCEDURES

There are a number of criteria that now must be met for participation in the Community Care Program. In addition to being a U.S. citizen and state resident, applicants must be at least 60 years of age, must establish that their non-exempt assets do not exceed $10,000 and must demonstrate an appropriate level of need for CCP services.* Following a determination that an applicant meets the citizenship, residency, and age and asset requirements, each applicant is assessed, using a standardized "Determination of Need" (DON) assessment instrument. After the DON is completed, it is given a numerical score. Applicants whose DON scores are above the established minimum, are determined to be in sufficient need to warrant services.

However, whether or not an applicant is considered appropriate for the CCP program is decided on the basis of two additional, somewhat related, factors. Since case managers also have responsibility for nursing home pre-screening, the SUA has

*Since exempted assets include home and automobile ownership, which are among the most typical and least liquid high value assets of older people, it appears that this criterion has had very little impact on program participation. The issue of income levels and how they effect participation will be discussed in the following section.

determined that the DON be used for this purpose as well. Applicants who clearly require the scope and intensity of care provided in an institutional setting — as reflected in scores on the high end of the scale — are approved for Medicaid-reimbursable nursing home placement. In those cases where this decision is not clear cut, a cost factor is introduced into the CCP appropriateness determination. If the plan of care prepared by the case manager indicates that the projected CCP costs are expected to exceed established group care costs, which are keyed to minimum/maximum DON score ranges, an applicant is determined not to be appropriate for the Community Care Program.* Finally, if care plan costs fall within the maximum amounts, physician approval of the care plan is necessary to confirm the case manager's appropriateness decision.

To summarize: eligibility for participation in the CCP, in addition to meeting various socio-demographic characteristics, is contingent on an applicant's demonstrating a need for LTC that can be met appropriately and cost-efficiently by the Community Care Program.

4. CLIENT COST-SHARING

Although income is not used as a basis for determining client eligibility, it is a major feature of the Community Care Program and has a significant effect on client participation. The sliding fee scale used in the CCP is applied to all participants whose individual or family income exceeds established protected amounts. For individuals, the protected amount is a monthly income of $426 or less; for a family of two or more, the amount increases to a maximum monthly income of $639.

*The established group care cost factors reflect the public costs for care that is provided in an institutional setting. Two maximum monthly cost amounts are keyed to DON score ranges. For applicants who score in the mid-range, the monthly maximum CCP cost cannot exceed $598; for higher range scores, the maximum cost is increased to $980 per month. In cases where two or more members of a household would be receiving CCP services, the state has established an adjustment formula that takes this factor into account.

The CCP sliding fee scale relies on the following formula for determining monthly client fees:

$$\text{MONTHLY FEE} = (\text{monthly income less protected amount}) \times \frac{\text{monthly CCP costs of care}}{\text{group care maximum amount}}$$

The effect of the fee scale formula is that the higher the monthly cost of care, the greater the proportion of available monthly income required to be paid toward the costs of care. In theory, although it has been reported that this happens rarely, clients can be responsible for paying the full costs of the services they receive as participants in the Community Care Program. Although the protected amount might be challenged as being too low to meet the basic necessities of daily living, the formula does create a "prudent purchaser" approach on the part of the participating client. It also has been suggested that it serves to discourage those who might like to receive the services that are available, but who do not truly need them. On the other hand, the formula ensures that those individuals whose incomes are minimal (below the protected amounts), will receive the services they need that are available from the program, at no cost to themselves.

According to current procedures, vendors are responsible for collecting client fees. The SUA reimburses vendors monthly for the actual negotiated costs of each unit of service delivered during the previous month, minus the calculated client fees generated for the month. If a client fails to make payment to the vendor for the difference, the SUA policy is that services can be discontinued. It has been reported, however, that in practice when a bill is not paid, the more usual procedure is for an arrangement to be worked out in conjunction with the CCU case manager, the vendor and the client, so that services are not discontinued and the client is not placed in jeopardy.

5. COMMUNITY CARE PROGRAM FINANCING

Although there have been several changes in the assumptions regarding both the source and amounts of federal reimbursement for state expenditures related to the CCP, state general revenues have continued to be the principal source of funding for the program. Since its initial $9 million state appropriation, following its transfer from the Department of Public Aid to the Department on Aging in 1979, the amount of general revenues for the program have grown markedly. The state's FY 1985 appropriation is $53 million, reflecting an almost 600 percent increase over a six year period.

For the first two years of funding the program within the IDOA, the state appropriation assumed some federal reimbursement would be forthcoming under the provisions of Title XX of the Social Security Act. However, this turned out not to be the case; state expenditures had by then already exceeded the optimal 25/75 state/federal match ratio to draw down its full Title XX allotment. Therefore, while the state continued to receive reimbursement for Title XX-related expenditures, the impact was only on the match ratio; it had no effect on the total amount received.

State general revenues continued to provide primary support for the CCP, without any expectation of federal reimbursement, until 1983, when the state received approval of its request for 2176 waivers. The financial impact of the approvals was that the state could again anticipate federal reimbursement for its CCP expenditures, for those CCP clients who were enrolled in the state's Medicaid Program. According to the latest figures available, it appears that approximately 30 percent of the CCP caseload are enrolled, although an examination of client characteristics indicates that perhaps another 5-10 percent are potentially eligible to apply for Medicaid

coverage.*

Despite the fact that the SUA operates the Community Care Program in accordance with the 2176 waiver specifications, it is clear from the above that Medicaid reimbursement is not a major source of program funding. Assuming that the costs of care of Medicaid-covered clients are on average the same as those for the total client population, Illinois can expect to receive federal Medicaid reimbursement for only 15 percent of its total CCP expenditures, given its standard Medicaid reimbursement rate of 50 percent.

*An even higher proportion of participants is projected to be potentially eligible, if it were not for the Medicaid Program's $1500 asset limitation, which cannot be waived under the 2176 provisions.

The Colorado Aging and Adult Services Division Home and Community-Based Services Program

A. Historical Context

The Colorado State Unit on Aging was not significantly involved in LTC-related services and programs prior to being given responsibility for implementing and managing Colorado's Home and Community-Based Services (HCBS) Program. Since it was established in the mid-1960's and through the 1970's, the Colorado SUA, which is housed within the Department of Social Services, functioned as the designated single state unit responsible for fulfilling the mandates of the Older Americans Act. In this capacity, its activities included administering Older Americans Act resources and serving as an advocate for older people in the state.

When the 1978 Older Americans Act amendments established in-home services as a priority area, the Colorado SUA and its 15 substate AAAs incorporated this interest into their advocacy and funding efforts. However, given the relatively low visibility of the Network, and the limited resources the SUA and AAAs had available to them, these efforts also were limited in terms of their scope and their effects.

By 1980, however, the need for system change was beginning to be felt in the state. Both within state government and among advocates for aging services, several major concerns had begun to surface. One of the principal emerging issues related to the costs and service inefficiencies inherent in the existing state structures for long-term care program development and service delivery. At least on a conceptual level, a number of key officials and legislators were recognizing and beginning to acknowledge that Colorado's traditional approach to the organization and delivery of LTC services — which had been established and was functioning more or less in accordance with federal funding streams — was exceedingly costly, in financial terms as well as with respect to responsiveness to client need.

The system development grant received by the state in the Fall of 1980 provided a catalyst for system change. During the grant implementation period, all of the state level agencies involved in LTC were brought together to examine in detail the problems that existed with respect to LTC services in Colorado and to develop corrective recommendations. In December, 1981, one recommendation -- to reorganize the Division of Services for the Aging and expand its functions to include key programs serving older people and non-aged adults — was approved by Colorado's Governor. Among the services and programs that were transferred to the newly named Aging and Adult Services Division (AASD) were the state's Home Care Allowance entitlement program and the adult foster care and protective services programs that had been administered by other units of the Department of Social Services prior to the reorganization effort.

The timing of the SUA's reoganization, reflecting the state's decision to begin realigning its programs on a functional or client basis rather than simply by funding source, was also propitious specifically with regard to LTC. Following federal passage of the 1981 Omnibus Budget Reconciliation Act, Colorado, like Illinois and a number of other states, took advantage of the Act's 2176 provisions. By the summer of 1982, the state received federal approval to waive several extant Medicaid regulations, allowing it to expand a two-site alternative care pilot project that had been initiated in 1981 by the state's Medicaid agency, into its current statewide Home and Community-Based Services Program. Furthermore, in line with the underlying rationale for the state's reorganization effort, responsibility to implement and manage the statewide Program was given to the AASD rather than the Medicaid agency.

As will be seen from the program description that follows, implementation of the HCBS Program, which began operating in early 1983, significantly expanded the

community care services base for older people and non-aged adults in Colorado. In addition, the state's decision to transfer program management from the Medicaid agency to the AASD has elevated the SUA from a relatively small organizational entity with limited responsibilities and resources to a crucial position with respect to Colorado's LTC program development and service delivery efforts.

Nevertheless, despite the expanded program scope and considerable broadening of the SUA role and responsibilities in relation to community-based LTC, the HCBS Program currently continues to rely significantly on the state's pre-existing structure and process for administering Medicaid. While the SUA has assumed a number of the functions normally associated with the state Medicaid agency, the substate administrative and service delivery structure looks very much like that of the state's traditional Medicaid Program.

The remainder of this section presents a description of the current HCBS Program -- what it looks like and how it now operates. However, it should be kept in mind that the program is still in its early stages of implementation and is currently undergoing extensive review, in order to make its administrative and service delivery components more efficient and effective. While it is too early to specify what modifications are likely, it seems certain that actions to streamline the program's administrative and management structure and process will be occurring as the program continues to evolve.

B. Summary Description of the Current Colorado HCBS Program

1. PROGRAM STRUCTURE

The Colorado Home and Community-Based Services Program, which is currently serving approximately 1450 elderly and non-aged adult clients each month, operates through a relatively complex administrative structure. In addition to a number of

local service providers and case management "agencies," the County-based Medicaid units and several state level agencies are critical to program implementation. The various components of the HCBS Program and their functions are summarized below.

a.) Direct Service Providers. HCBS service providers, which can be either agencies or individuals depending on the type of service provided, are not identified through a formal competitive process, nor are they under a specific contractual agreement to deliver program services. However, because of Medicaid regulations, they are required to be certified in order to be included within the pool of HCBS providers eligible to receive program reimbursement. The certification process for agency providers is performed by the state Department of Health, acting as an agent for the state Medicaid agency. Certification responsibilities for individual providers rest with the County-based case management agencies, acting on behalf of the State Unit on Aging.

b.) Case Management Agencies. While they are called case management "agencies," with few exceptions, HCBS Program case management functions are performed by personnel from County Departments of Social Services (C/DSS). Case management agency (CMA) staff are responsible for client assessment, care planning and services acquisition and monitoring, using a standardized assessment instrument.

In developing client care plans, case managers attempt to access non-HCBS resources to the extent possible to complement the HCBS Program services directly available to program participants. In terms of determining care plan costs, however, only HCBS Program services are included in cost calculations. For those HCBS Program services recommended in the care plan, case managers contact the specific service providers they propose to utilize, to confirm the provider's availability and unit rate. Care plans are then costed out and HCBS Program service cost summaries are

submitted to the SUA for review and approval.

In addition to their specific client-related functions, CMAs also are responsible for invoicing the HCBS Program for individual provider services and for making payments to individuals for the services they rendered. The administrative costs related to these responsibilities, as well as the client-related assessment and case management functions, are reimbursed to the CMA by the program.

According to Medicaid regulations, CMAs are also considered providers, and therefore must be certified in order to receive Program reimbursement. For CMAs, certification requirements include the submission of an operational plan, which addresses such issues as service need and service availability in their catchment area, and how these will be linked to the operating program they propose. The responsibility for certifying CMAs rests with the SUA.

c.) County Departments of Social Services. Since the HCBS Program operates entirely under the state's Medicaid 2176 waiver proposal specifications, in addition to meeting the level of need determination requirements, program participation is also contingent on an applicant's meeting income, asset and other socio-demographic Medicaid eligibility requirements. Authority to make these determinations currently resides in the Medicaid Eligibility Units of the County Departments of Social Services. Case managers, therefore, in conjunction with initiating their formal assessment and care planning functions, also forward an applicant's request for HCBS Program services to the C/DSS Medicaid Unit for Medicaid eligibility determination.

d.) The Colorado Foundation for Medical Care. In addition to the income and asset level and other requirements for Medicaid eligibility, applicants also must meet the HCBS Program functional disability criteria for participation. Responsibility for these level of need determinations rests with the Colorado Foundation for Medical Care (CFMC), which serves as the state's PSRO and which also has statewide

responsibility for determining level of need for nursing home placement under the Colorado Medicaid Program. As the process currently operates, PSRO nurses utilize the same approach and instrument for making both nursing home and HCBS Program level of need decisions. These decisions are based primarily on a review of a standardized application form, supplemented as needed by telephone discussions with the applicant's physician and, in some instances, with the referring agency.

If the referring agency is a CMA, notification of those applicants who meet the appropriate level of need for HCBS Program participation is transmitted to the CMA. If the referring agency is not a CMA, but the applicant's level of need is determined to be appropriate for the HCBS Program, both the referring agency and the relevant CMA are so notified.

e.) State Fiscal Agent. All HCBS Program billings and payments for direct service provision and for CMA assessment and case management functions are processed through the state's Medicaid Management Information System (MMIS). The MMIS is managed by a non-governmental contractor, who serves as the Medicaid fiscal agent for both the state's Medicaid and HCBS Programs.

CMAs and agency providers submit invoices directly to the fiscal agent. When approved, claim payments are made against the billings. The MMIS, which contains data on each eligible HCBS client and each certified provider, is used as the screen for approving invoices for payment, based on the prior authorizations for service that are provided by the SUA. The fiscal agent also utilizes the MMIS to generate a number of reports, which are transmitted to the SUA in order for it to be able to track fiscal and program activities of the statewide program.

f.) The State Unit on Aging. In addition to its specifically mandated functions with respect to area agencies and other Older Americans Act activities, and its responsibilities in relation to several state-mandated non-HCBS Program services,

the Colorado Aging and Adult Services Division has responsibility for managing the various HCBS Program components described above. Although ultimate authority for client eligibility determination and provider certification does not fall within its purview, the SUA plays the major state level role in terms of operational management for the state's community-based LTC program. In this latter capacity, its functions include establishing program and fiscal policies and providing assistance as needed in their implementation; providing prior authorization for care plan implementation and payment for HCBS Program services; collecting and analyzing relevant program data; tracking client and provider cost data from the MMIS and transmitting appropriate reports to CMAs; certifying CMAs for HCBS Program reimbursement; and performing a variety of administrative and management functions necessary to facilitate program operations.

2. PROGRAM SERVICES

The HCBS Program offers a variety of services to its participating clients. In addition to assessment and case management, the Colorado program provides reimbursement for a number of "non-traditional" Medicaid services, i.e., homemaker, personal care and respite services, adult day health care, non-medical transportation and environmental modification services (e.g., the purchase or installation of grab bars, ramps, emergency alert systems, etc.). However, what makes the Colorado program particularly unusual, at least among the 2176 waiver programs that are statewide and/or administered by agencies other that state Medicaid agencies, is that it also includes authority to manage the more traditional Medicaid non-institutional services, e.g., skilled nursing care, home health aide services and physical, occupational and speech therapy. All of the above-listed services, in whatever combination is needed, are available through the HCBS Program's assessment and case management sub-system to participating clients.

3. PROGRAM ELIGIBILITY CRITERIA*

The discussion of the HCBS Program structure included a description of the eligibility determination procedures to establish income and asset levels and to make level of care determinations. What follows is a more detailed description of what these and other program criteria are.

With respect to asset levels, all HCBS Program applicants must establish that their assets are not in excess of the non-waivable Medicaid Program maximum of $1500. With respect to income, all applicants must establish that they are either categorically SSI-eligible or that their individual or family income is not in excess of 300 percent of the current federal SSI benefit level. (Colorado's use of the 300 percent income maximum, which is normally restricted to institutional care income determination, was included as part of its approved 2176 waiver package.)

The level of care determination for Program partipation establishes that an applicant is both sufficiently functionally impaired to warrant long-term care services and that the LTC services available from the HCBS Program are likely to be appropriate to meet these needs in a non-institutional care setting. This latter decision, which is made by the Colorado Foundation for Medical Care as part of the overall level of care determination, is not absolutely binding on applicants. Currently, applicants retain the option to choose Medicaid-reimburseable nursing home care, even when they are deemed appropriate for HCBS Program participation.

As stated previously, the Medicaid Eligibility Units of the County Departments of Social Services are responsible for determining an applicant's eligibility for Medicaid coverage of HCBS Program services. In order to apply the eligibility certification process, in addition to establishing that applicants do not exceed

*Since eligibility determination procedures were discussed in the program structure section, they will not be repeated here.

the Program's income and asset levels, the Unit also is responsible for determining that applicants are U.S. citizens and state residents.

Finally, because the program serves non-aged adults as well as older people, the age minimum for participation is 18 years and older. In terms of categorizing program clients, age 65 is used to differentiate the aged from the non-aged clients participating in the program.

4. CLIENT COST SHARING

Although the 300 percent income rule permits individuals whose incomes are in excess of the maximum SSI benefit levels to participate in the HCBS Program, these "300 percenters" are required to share in the costs of their HCBS care plans. On the other hand, categorically-eligible program participants are considered to have incomes within the protected amounts established for the program, and therefore do not have to contribute to their costs of care.

The cost-sharing component of the HCBS Program is based on a sliding fee principle which, like the Illinois CCP, reflects a "prudent purchaser" approach to program participation. In Colorado, a non-categorically eligible client's income, minus a protected amount, must be used to offset care costs. If care costs are greater than available income, then the available income amount is considered as partial payment against costs. If care costs are less than the available income amount, then the full costs of care are required to be paid.

The basis by which the protected amount is determined is as follows: the base amount is the state's Old Age Pension level of $383/month (with an incremental adjustment for dependents), plus the client's health insurance premium, plus any outstanding medical bills.

Given the gross income maximum of 300 percent of federal SSI benefit levels, coupled with the factors that are taken into account to establish the protected

income amount, cost share payments can vary considerably, as a function of clients' financial circumstances and costs of care. Nevertheless, once the cost-share amount is established, clients are required to make full payment of that amount, unless either their income or liability expenditures change or their care plan and its associated costs are altered. Should any of these amounts change, then the cost-share amount will also be changed accordingly. The HCBS Program policy is that if a client refuses to participate in sharing his or her costs of care, program termination procedures are initiated.

Finally, HCBS Program providers are not responsible for collecting client fees. Client cost-sharing fees are paid to the case management agency which, in turn, submits them to the SUA. Providers are paid through the MMIS for the invoices they submit for reimbursement for the units of service they deliver.

5. HCBS PROGRAM FINANCING

Although the HCBS Program is extremely complex administratively, its financing is very straightforward, at least in principle. The entire program is financed by state revenues, conditioned on the state's expectation that it will receive its standard 50 percent Medicaid reimbursement from the federal government.

From its inception in February, 1983 through June 30, 1984 (the end of the Colorado fiscal year), program expenditures amounted to $3.37 million, of which the state is expecting federal reimbursement in the amount of approximately $1.68 million. For fiscal year 1985 (July 1, 1984 through June 30, 1985), the HCBS Program line item budget appropriation is $2.49 million, again based on the assumption that the federal Medicaid reimbursement back to the state will be 50 percent of the actual amount expended for the period.

IV. CONCLUSION

Since the early 1970's, beginning with the Massachusetts Home Care Program initiated in 1972, and followed a year or so later by the Pennsylvania community-based LTC program initiative, State Units on Aging have increasingly been directing a considerable portion of their energies and resources toward broadening the definition and scope of long-term care. During this period, increasing numbers of SUAs have begun playing a more visible and instrumental role — as advocates, addressing the full range of long-term care issues affecting older people and, perhaps even more strikingly, in their active efforts to focus attention on and promote support for community care as a necessary and legitimate LTC service modality. In addition to their encouraging the utilization of available Older Americans Act resources to support community-based LTC services and programs at the substate level, a number of SUAs across the country have been successful in their efforts to influence state policies and to generate significant amounts of additional support for community care services.

The statewide community-based LTC programs described in this report are illustrative of the significant role that two State Units on Aging currently are playing with respect to LTC program development and service delivery. It is to be hoped that readers will not compare the two programs and attempt to make judgments about which is the "better" of the two. What is important is that both the similarities and differences that characterize the two programs emerged out of each state's unique historical, political, fiscal and programmatic environment. In conclusion, although the programs that are currently operating in each state are very different, and reflect considerably different approaches, they nevertheless are indicative of what can be done, given a state level commitment to begin the LTC system change process.

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